

Exhibit J

Pelvic Floor Repair – Surgeon's Feed-back on Mesh Concept

Feed-back was obtained through conversations and interviews with 21 surgeons from US, UK, Sweden, Finland, France, Italy, The Netherlands, Germany.

The following summarizes the individual interviews:

Prof. Petri, Schwerin,, Germany

Annual procedures at his hospital:

270 abdominal colposuspension (Burch) for stress urinary incontinence treatment
80 TVT for stress incontinence in older patients (abt. 60 and older)
81 180 vaginal repairs (80 for cystocele, 100 for rectocele)
90 sacrocolpopexies for vaginal prolapse

Prof. Petri thinks these numbers are high, for two main reasons: 1. His patients come from the rural areas and carry a high risk to develop vaginal prolapse because of obesity, multiple vaginal deliveries, heavy work, smoking habits, 2. He has patients from distant areas (~~even from Aachen~~), because he is renowned for pelvic floor surgery and because gynecologic surgeons with these special skills are rare in Germany with these special skills.

He states that many of the patients who are referred to him for anterior or posterior vaginal wall prolapse, do not have any clinical symptoms. He usually operates only when the patient complains about symptoms, he does not do this operation for cosmetic reasons. But he states that there are many surgeons who do exactly that, they treat the bulge they see inspecting the vagina from inside, even though the patient had not uttered any complaint at all with that bulge. The anterior and posterior colporrhaphy may lead to narrowing of the vagina to such an extent that sexual intercourse causes considerable pain. So often it happens that the patient who was symptomless before the operation, suffers after treatment.

The sacrocolpopexy is carried out by him following a technique described by Richter. He uses a vaginal approach and Ethibond sutures. The failure rate is 1-2 cases out of the 90. There is a risk of mechanical bowel obstruction in that area.

Prof. Petri would like to use mesh for this operation, ideally a combination of long-term absorbable and short-term-absorbable. He is confident that the adhesions formed will remain, once the mesh has totally been absorbed. The mesh must be cuttable without fraying.

He has used Vicryl Mesh, Gynemesh or Prolene Mesh for repair of extreme rectal prolapse. The current polypropylene meshes are considered too thick and too rigid, not only at the edges, but in general. One patient in whom he had used polypropylene mesh for rectocele repair, had experienced an erosion with infection. Therefore, he does not use polypropylene mesh any longer for rectocele repair. He also had tried Mersilene Mesh, yet abandoned it also, because of infections.

He would never use mesh material for anterior vaginal wall repair, because he thinks this is a very delicate area, with the nearness of the bladder neck and a risk of the mesh eroding into the urethra, bladder neck or bladder.

His experiences with biological materials for rectocele repair, such as bovine pericardium, are disappointing, he stopped its use because of severe tissue reactions. He has used lyophilized dura or xenogenic fascia lata, but with both materials he has observed fast degradation resulting in recurrence.

Prof. Petri emphasizes that the pelvic floor pathology is a challenging area for the surgeon. With his awareness of the need to improve surgical techniques in pelvic floor repair, he has been trying to improve his technique for the past 19 years and yet has not reached a stage of satisfaction with his results so far.

Prof. Koelbl, Halle, Germany:

His preferred technique to treat cystocele, is the anterior vaginal colporrhaphy, with Vicryl Z-suture for reduction of cystocele, minimal tissue resection. The procedure can easily be combined with TVT, however requiring spinal anesthesia.

For rectocele, he does a posterior colporrhaphy.

For vaginal prolapse repair, he prefers the colposacropexy using Ethibond sutures. In recurrences, he uses Prolene Mesh, he would prefer Soft Prolene Mesh in these cases.

He thinks that Vypro is too elastic for colposacropexy. In some patients tissue incorporation is not very strong, so here he fears that the elasticity of the remaining Prolene mesh (after absorption of the Vicryl portion) is too high resulting in recurrence.

Dr. Fischer, Wiesbaden, Germany:

He has done 200 pelvic floor repairs, anterior, posterior, combinations of both, and sacrocolpopexy, for the past two years, first using Gynemesh, then switching to Vypro after he had become aware of this new mesh.

during intercourse
Gynemesh: is perceived as too bulky, and rigid. Also, when cutting the mesh, small particles are released that migrate through the vaginal wall causing pain. Dr. Fischer thinks that Gynemesh will never be a success, also for cost reasons. Many surgeons would buy the cheaper Prolene mesh, cut it themselves and then resterilize it. This could obviously not be done with the Vypro mesh.

Vypro Mesh:

minimum
The advantages he sees: thin, elastic, cuttable without fraying. Should be offered in different sizes, e.g. 5 x 15 cms for the anterior colporrhaphy, 7x12 cms for posterior colporrhaphy. He uses Gore tex suture for fixation. ~~To be improved:~~ The mesh should have less retraction when incorporated in the fibrous tissue. For handling, some added stiffness would be preferred. The mesh is well incorporated, at postoperative examination, the vaginal wall above the mesh feels soft, no resistance can be felt, whereas Prolene mesh could easily be felt through the vaginal wall by the examiner (the patients themselves did not complain). In his series of 200 patients he has seen two cases of erosion, one with Prolene the other with Vypro. Both

patients had hematoma before. Wound healing disturbances totalled 10 % (exact rate for Vypro yet to be evaluated).

According to Dr. Fischer, wound healing disturbances are frequent in vaginal surgery – rather the rule than the exception, also with conventional colporrhaphy using sutures.

Prof. Jacquetin, Clermont-Ferrand, France

He is renowned for his experience with pelvic floor surgery, a recognized centre of competence within the area. So he thinks that his number of 35 cases with large cystoceles per year, is high.

He has used Vypro mesh, 10x15 cms, for pelvic floor repair in about 20 patients so far and he has agreed to send us his report on preliminary results. He treats particularly large cystoceles, including medial and paravaginal parts, with mesh. Large cystoceles are sometimes 10 cms in diameter. He fixes the mesh with Prolene sutures to the muscular fascia (arcus tendineus).

Following Vypro mesh implantation, the patients always had a very soft elastic vaginal wall (which was not so with Prolene mesh which through its stiffness and bulkiness, could easily be felt through the vaginal wall tissue).

Prof. Jacquetin likes the Vypro mesh, he regards it as much better than Prolene mesh or any other mesh on the market, and he will continue using it, but he also states that it is not the optimum solution.

He has observed two issues:

1. Patients complain of lateral pains. He thinks that this could be due to fixation using the nonabsorbable sutures that come under tension while the mesh retracts during tissue incorporation. He has also observed this phenomenon with Prolene mesh.
2. He has had some patients (number to be determined) with wound healing disturbance following Vypro implantation. Wound healing was compromised in the middle of the vaginal incision. But it did not become necessary to remove the mesh.

Prof. Falconer, Stockholm, Sweden

Dr. Falconer has used Gynemesh / Prolene Mesh for anterior colporrhaphy in recurrent cystocele. He has not encountered any infection with Prolene Mesh which he sees as inert and biocompatible. He reduces the cystocele first by absorbable sutures before implanting the mesh. He suggests a mesh size of 7x7 cms.

He thinks that Vypro mesh could be a good alternative to the present bulky Gynemesh. He sees an advantage in having less foreign body material remaining.

He would not use any mesh material for rectocele repair, implanting it between posterior vaginal wall and rectum, as he is concerned that there may be complications because of the vicinity of the bowel, with a potential risk of bacterial contamination.

For sacrospinal fixation, he uses Ethibond sutures.

Prof. Nilsson, Helsinki, Finland

Prof. Nilsson thinks that a lot of cosmetic surgery has been done to repair cystoceles. He will not operate on any asymptomatic cystocele.

According to his experience, medial pelvic floor defects are frequent, lateral defects are rather rare.

In a patient with both, symptomatic cystocele and stress incontinence, he will first complete the TVT procedure, then 2 cms beneath the incision for TVT, he will do the incision for a conventional anterior colporrhaphy.

He has not used mesh implants for pelvic floor repair, but would consider using a fine mesh (e.g. Vypro mesh) for recurrent cystocele. However, it is not clear to him how the mesh could be fixed, since the tissue is too fragile for anchoring sutures. The mesh should stretch equally in both directions. He thinks that the mesh repair will probably delay the recurrence, but not avoid it completely, as with aging, the pelvic floor continues to descend.

Prof. Nilsson is sure that a totally absorbable mesh material will not work long-term, since the long-term effect depends on the tissue reaction to the implant material. Once the material is gone, the tissue reaction will subside. He explained his experience with intravaginal sling procedure for stress incontinence therapy, using Mersilene tape. With the hypothesis that the Mersilene tape was required only for a certain time, he took it out after 60 days. At first, the results remained good, obviously because of the adhesions in place, but after some time the patients gradually became incontinent again.

Prof. Cardozo, London, England

Prof. Cardozo has already some experience with Vypro mesh. She uses it for recurrent anterior vaginal wall prolapse (cystocele). She would very much like to carry out a clinical study with Vypro Mesh for that indication. Her technique: she reduces the cystocele by a Vicryl purse string suture, with sparse tissue resection, then she buttresses the suture repair with a Vypro Mesh, a square sized 5 x 5 cms is considered sufficient.

For sacrocolpopexy she uses Mersilene Mesh which she doubles so that it gets the shape of a tube. She thus avoids sharp edges and the risk of eroding the bowel wall. Mersilene and Prolene meshes both have too sharp edges, according to her.

Ideally Prof. Cardozo would like to have a long-term totally absorbable mesh for all these indications. She is confident that the buttressing effect will remain after the implant material has disappeared.

Dr. Lucente, Allentown, USA

Dr. Lucente is convinced that there are much more lateral and apical defects than medial cystoceles. He also believes that many gynecologists do not perform the examinations correctly to assess the defects properly. Sometimes patients are sent to him for operation who have a cystocele but no symptoms. He will not operate on these.

For anterior vaginal wall prolapse repair (cystocele), he always uses the laparoscopic approach. So in patients with combined stress incontinence and cystocele, he will not use TVT, he will do a laparoscopic paravaginal repair combined with laparoscopic Burch colposuspension, using Ethibond sutures.

He has used Prolene Mesh or Gore Tex for laparoscopic colposacropexy. Particularly, the Gore Tex he finds supple and easy to work with.

He has not used mesh for anterior or posterior vaginal wall repair.

Dr. Lucente thinks the Vypro mesh is an interesting material. It could be worth trying it as a buttress material for his paravaginal suture repair (laparoscopic approach).

Dr. Migliari, Italy

Since 1995, Dr. Migliari has used Gynemesh to treat recurrent cystocele, now he has started using it also on primary repairs.

According to his experience, 70% of the cystoceles start in the centre, where the fascial tissues is very fragile, anyhow. By the time the patient comes to see the gynecologist, usually the lateral parts are already involved, too.

Dr. Migliari uses the grading system to decide on whether to treat or not.

Grade I and II: no correction needed.

Grade III and IV : to be corrected

He does not think it is necessary to bring the cystocele back to 0 in elder patients. It is quite adequate to restore it to grade I.

Cystocele repair: Small incision in the vaginal wall about 1-2 cms beneath the usual incision site for TVT. Vaginal approach like in conventional anterior colporrhaphy.

Gynemesh is fixed tension-free with 4 corner Prolene sutures to the paravaginal fascial tissue (earlier, Dr. Migliari used Dexon or Vicryl, but he abandoned absorbable sutures after a case of wound healing problem). Dr. Migliari does not resect any tissue when closing the vaginal wall wound. He just approximates the wound edges, it does not matter if the tissue is very loose hanging a bit into the vagina, according to his experience. The surplus tissue will gradually disappear leaving a smooth vaginal wall.

If the patient has both stress incontinence and cystocele, Dr. Migliari first starts with TVT, then repairs the cystocele and last completes TVT.

The advantage of tension-free repair: the patient does not experience pain postoperatively. Usually, after conventional colporrhaphy, the patient is suffering considerably, as the suture to reduce the cystocele is placed under tension.

Dr. Migliari perceives the bulkiness of the Gynemesh as disadvantageous. The mesh can be felt beneath the vaginal wall. He demonstrated great interest in Vypro mesh.

Prof. Ulmsten, Uppsala, Sweden

The concept of tension-free mesh placement for pelvic floor management was presented to Prof. Ulmsten.

He thinks that for success, a device concept was needed, not just a mesh implant, perhaps a mesh with glueing properties, or a long-term absorbable mesh with incorporated active proteins. So far, Prof. Ulmsten does not have a specific concept for pelvic floor management. The idea of tension-free mesh is ok, but not optimum. He will have to look into this more deeply.

Dr. Hardiman, London, UK

He has carried out a study using Gynemesh for repair of isolated cystocele, without other concomitant pelvic floor defects. 20 patients were recruited and operated on.
 Technique: Vaginal wall incision abt. 2 cms away from the incision as done for TVT.
 Dissection of vaginal wall from bladder. Both structures are connected with each other by connective tissue layers. Dissecting causes very little bleeding. Gynemesh is placed between bladder and vagina and it is fixed tension-free with a total of 5 stitches Vicryl, at the two proximal corners, at the 2 distal corners and 1 distal in the centre of the mesh edge, to the paravaginal connective („fascial“) tissue .
 The cystocele is not reduced by purse string or other sutures as is generally done in conventional colporrhaphy.
 This means that the concept is truly tension-free. Following mesh implantation, the vaginal wall wound is closed with Vicryl in a continuous suture. Scarce resection of surplus tissue.

In two patients, Dr. Hardiman has observed a wound healing disturbance right in the middle of the vaginal wall wound . The wound did not close above the mesh. There was no infection and the patients were not aware of the erosion. To overcome this problem, Dr. Hardiman will change to a technique described by Julian who sutures the vaginal wall in a double layer above the mesh implant, because he feels this overlapping could prevent mesh erosion.

Dr. Hardiman likes the Gynemesh , but he thinks a thinner mesh could be more acceptable to surgeons. He could not tell if he would prefer Vypro or just another thinner mesh such as Soft Prolene Mesh. Both concepts seem plausible to him. It is important that the mesh can be cut to individual sizes, it must not fray nor release particles.

He does not see mesh rigidity as a problem. The stiffness of the mesh helps to restore the former bulge without adding sutures. The cystocele bulge is no longer visible after the operation. It has completely disappeared .

Dr. van Leffern, Hamburg, Germany

According to Dr. van Leffern, urinary stress incontinence and cystocele are often combined. He could not tell, however, in what percentage. He thinks the cystoceles are predominantly medial. He is not aware of lateral defects.

It is also quite frequent that the patient presents only with a cystocele and, no stress incontinence is demonstrable in preoperative urodynamic evaluation, but some months after the cystocele repair, the patient develops urinary incontinence.

In patients with cystocele only , Dr. van Leffern repairs only the cystocele by vaginal anterior colporrhaphy. Once the patient returns with stress incontinence, he will carry out a second operation , implanting TVT.

Dr. Hilton, Newcastle upon Tyne, UK

For cost reasons, he has not used Gynemesh, but strips of Prolene mesh which he cut and resterilized. On principle, he uses meshes only in recurrent anterior and posterior vaginal wall prolapse, for anterior and posterior colporrhaphy. Although he is aware that results of this primary repair are unsatisfactory, with 30% recurrence, he is concerned with using meshes for primary repair, because there is always the risk of erosion or extrusion. At this stage, it is not possible to predict whether the use of mesh for primary repair would improve 5 year results.

Thinner meshes such as Soft Prolene Mesh or Vypro would certainly be an improvement to the current Prolene Mesh which is very thick. As the mesh always must be cut to individual

sizes, it is of utmost importance that the mesh is cuttable and that it does not fray nor release particles after cutting. The small particles migrate and cause pain during intercourse.

For improved handling during implantation, the mesh should not roll at the edges (such as the Ugahary mesh, 110).

Dr. Hilton does not know what biomechanical requirements a mesh must fulfil to withstand the forces on the pelvic floor. He assumes that pressure is higher at the pelvic floor level than at the abdominal wall.

Dr. Ralph, Graz, Austria

He will not use any mesh for pelvic floor repair. In the past, his colleagues were quite enthusiastic about meshes. Later on, there was the disappointment, with meshes leading to erosion and extrusion. He has no experience himself. This is what he heard from other surgeons.

Prof. Felberbaum, Lübeck, Germany

He has never thought of using meshes for pelvic floor repair. He does the usual vaginal anterior and posterior colporrhaphy. He does not feel that he could comment on such a concept.

Prof. Eggers, Germany

Is not a TVT user. Would use PP mesh for pelvic floor, but he considers the use of meshes as last choice for pelvic floor repair. They are a just a sort of „band aid“, for pelvic floor defects.

Prof. Corterier, Hamburg, Germany

He will repair a vaginal wall prolapse only if the patient has symptoms or if he thinks it is justified to do the repair.

He carries out the usual vaginal anterior and posterior colporrhaphy. He is happy with the results. He has never used meshes for pelvic floor repair and does not see a need to do so in future.

Prof. Mettler, Kiel, Germany

In her hospital, vaginal wall prolapse is treated by vaginal anterior and posterior colporrhaphy.

Occasionally, meshes have been used, but she is not aware which mesh products. She would have to ask the OR nurse.

She herself would prefer to do the repair by laparoscopy, as this approach allows you to overview and judge the stage of descensus very well. However, there is a lack of appropriate equipment and instrumentation for laparoscopic mesh repair. For example, laparoscopic sacrospinal fixation using meshes would require a finer stapler. Suturing with curved needles is difficult in laparoscopy.

Dr. Tunn, Berlin, Germany

He has experience with Prolene mesh which he uses in strips of abt. 5 cms x 1.5 cms , for bridge plasty. The mesh is placed beneath the medial part of the urethra, double fixation with Vicryl to the pubococcygeus muscles.

Before using Prolene mesh, Fascia lata was the material of choice.

The disadvantage of Prolene mesh is its thickness. One could feel it through the vaginal wall when examining the patient. Dr. Tunn has observed erosions in a number of patients, which he attributes to mechanical irritation of the mesh. He treated those erosions by simply cutting off the mesh at the erosion site. There was never a case of infection and the wound always healed. He considers the Prolene mesh as really inert material. However, he would be happy with a thinner mesh, soft Prolene Mesh of Vypro would probably both do well. He is not sure if he really needs an absorbable part in the mesh.

Dr. Tunn thinks the biomechanical requirements for a mesh for pelvic floor repair correspond to those of abdominal wall closure, probably even less . He believes that a totally absorbable material would not do the job., but lead to recurrence long-term.

Dr. Vierhout has about 100 patients with cystocele grade III and IV. He advises them to use a pessary device for a couple of weeks to identify those abt. 10% patients who have accompanying stress urinary incontinence.

He does a vaginal anterior colporrhaphy, Kelly plication using Vicryl sutures. The procedure can easily be combined with TVT.

So far, he does not have experience with mesh implants in these operations.

But he feels that the material should both be strong to withstand the forces exerted on the pelvic floor (more or less comparable to those on abdominal wall closure) and it should also be soft to avoid irritating the bladder.

Out of the three meshes demonstrated to him - Vypro, Vypro 2, SPM - he would favour Vypro. He would certainly try it once it is available.

He estimates that 18.000 pelvic floor prolapse procedures are done annually in the Netherlands.

He himself does abt. 80 vaginal anterior repairs per year, often combined with posterior (rectocele) repair.

If an abdominal hysterectomy is done at the same time, he will add the Burch colposuspension for prolapse repair. So far , he has used Gynemesh , fixed with 4 Vicryl sutures, in 4 anterior repairs, in one he observed an erosion in the middle of the vaginal incision.

Therefore, he would like to know the rejection rates of a new mesh.

He favours the Vypro for anterior and posterior repair, for its thinness and elasticity. He thinks the Gynemesh is too thick and stiff. The aim particularly of anterior vaginal wall repair is to create a thin scar tissue. The scar must not be too thick, because in that area, the original fascial tissue is very thin and fragile, and anything too bulky could have a negative effect on the bladder neck area. The tissue there is not comparable to muscular fascia. It is a loose connective tissue that connects the bladder and vagina with each other.

Dr. Verwest is not aware of any study that would address the forces exerted on the pelvic floor. He believes they are comparable to those on the abdominal wall. He therefore thinks that biomechanical properties of Vypro are adequate. However, he questions the necessity to add Vicryl. According to him, the Prolene part should be sufficient. He would definitely like to try Vypro and he strongly believes that Vypro would be a successful product in the pelvic floor market.

For sacrospinous fixation, he favours SPM, as - according to his experience - adhesions formed in that area around a mesh implant may be reduced in some patients. So Vypro could be too elastic once the Vicryl part is absorbed, leading to recurrence.